Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LAS PALMAS MEDICAL CENTER
10030 N MACARTHUR BLVD SUITE 100
IRVING TX 75063-5001

Carrier's Austin Representative Box
Box Number 17

MFDR Date Received
DECEMBER 5, 2011

Respondent Name
EL PASO ISD

MFDR Tracking Number
M4-12-1032-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rehab is excluded from TX W/C FS reimb. usual & cost is $750/day"

Amount in Dispute: $39,548.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute was not filed in a timely manner. According to rule 133.307(c)(1)(A), a request for medical fee dispute resolution is to be filed no later than one year after the date of service in dispute. The DWC date stamp indicates the request for medical fee dispute resolution was received on December 5, 2011, which is more than a year from April 2, 2010."

Response Submitted by: Argus Services Corp., 9101 LBJ Freeway, Suite 600, Dallas, TX 75243-2055

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2010 Through April 2, 2010	Inpatient Hospital Surgical Services	$39,548.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 21, 2010
   - 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

- 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*

Issue

1. Did the requestor submit the request for medical fee dispute resolution within 1 year from the disputed date of service?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are March 26, 2010 through April 2, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 5, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

		October 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		October 31, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.